

**WISCONSIN MEDICAID  
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR LAMISIL**

**INSTRUCTIONS:** Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Lamisil Completion Instructions, HCF 11180A.

Pharmacy providers are required to have a completed PA/PDL for Lamisil signed by the prescriber before calling Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) or submitting a paper PA request. Providers may call Provider Services at (800) 947-9627 or (608) 221-9883 with questions.

**SECTION I — RECIPIENT INFORMATION**

- |   |                              |
|---|------------------------------|
| 1. Name — Recipient (Last, First, Middle Initial) | 2. Date of Birth — Recipient |
| 3. Recipient Medicaid Identification Number       |                              |

**SECTION II — PRESCRIPTION INFORMATION**

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|--|-----------------------------------|
| 4. Drug Name and Strength  |                                   |
| 5. Date Prescription Written   | 6. Directions for Use             |
| 7. Name — Prescriber   | 8. Drug Enforcement Agency Number |
| 9. Address and Telephone Number — Prescriber (Street, City, State, Zip Code, and Telephone Number) |                                   |

**SECTION III — CLINICAL INFORMATION**

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|--|------------------------------|-----------------------------|
| 10. Diagnosis — Primary Code and / or Description  |                              |                             |
| 11. Has the recipient tried and failed on or had an adverse reaction to a preferred drug(s)?<br>If yes, indicate the most recent preferred drug the recipient failed and the approximate dates the drug was taken. |                              |                             |
|  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. Does the recipient have a diagnosis of onychomycosis?  |                              |                             |
|  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 13. Did the recipient have a positive potassium hydroxide (KOH) test, culture, or nail biopsy?   |                              |                             |
|  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 14. Does the recipient have another fungal skin infection such as tinea? If yes, indicate the condition.   |                              |                             |
|  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 15. Is the onychomycosis in the fingernail bed?  |                              |                             |
|  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 16. Does the recipient have a diagnosis of Type I or Type II diabetes?   |                              |                             |
|  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 17. Is the recipient immunocompromised? If yes, list the reason.   |                              |                             |
|  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 18. Does the recipient have a severe disability as a result of the fungal infection?<br>If yes, indicate the disability.   |                              |                             |
|  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

*Continued*

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**SECTION III — CLINICAL INFORMATION (CONTINUED)**

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19. **SIGNATURE** — Prescriber

20. Date Signed

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**SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA**

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21. National Drug Code (11 digits)

22. Days' Supply Requested (up to 365 days)

23. Wisconsin Medicaid Provider Number (Eight digits)

24. Date of Service (MM/DD/YYYY) (For STAT-PA requests, the date of service may be up to 31 days in the future and / or up to four days in the past.)

25. Place of Service (Patient Location) (Use patient location code "00" [Not Specified], "01" [Home], "04" [Long Term / Extended Care], "07" [Skilled Care Facility], or "10" [Outpatient].)

26. Assigned PA Number (Seven digits)

27. Grant Date

28. Expiration Date

29. Number of Days Approved

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**SECTION V — ADDITIONAL INFORMATION**

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30. Include any additional information in the space below. For example, providers may include that this PA request is being submitted for a recipient who was granted retroactive eligibility by Wisconsin Medicaid, BadgerCare, or SeniorCare.

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